Department of LABOR AND INDUSTRIES

Published by
Health Services Analysis Section
Olympia, WA 98504-4322

PROVIDER BULLETIN

PB 01-12

THIS ISSUE

Ambulatory Surgery Center Payment

TO:

Ambulatory Surgery Centers
Advanced Registered Nurse Practioners
Physicians (Medical & Osteopathic)
Physician's Assistants
Dentists
Podiatrists
Radiology Facilities
Clinics
Free Standing Emergency Rooms
Hosptials

CONTACT:

Provider Toll Free
1-800-848-0811
902-6500 in Olympia

Anaya Balter
Medical Program Specialist
PO Box 44322
Olympia WA 98504-4322
(360) 902-5021
(360) 902-4249 FAX

Email:
bala235@lni.wa.gov

EFFECTIVE: JANUARY 1, 2002

Purpose

This bulletin explains the new payment method, including policies and fees, for Ambulatory Surgery Centers (ASCs). It also replaces Provider Bulletin # 94-13.

This bulletin pertains to claims made against the State Fund and Self-Insured employers by injured workers and to Crime Victims. The fee schedule is ***effective for dates of service on or after January 1, 2002.***

Table of Contents

Page

- Purpose……1
- Background……2
- What is changing?……2
- Why are these changes being made?……2
- Who may bill for services?……2
- What if I already have a provider account as an ASC?……3
- What if I have a provider account as another provider type?……3
- How may an ASC obtain a provider account with the department?……3
- How may an ASC become accredited or certified?……4
- What services are covered in an ASC?……4
- What services are not covered in an ASC?……5
- What procedures are covered in an ASC?……5
- What procedures are not covered in an ASC?……5
- What if a procedure not on the ASC list needs to be performed in an ASC?……6
- What are the authorization requirements?……6
- What are the billing rules?……6
  - What form should be used?……6
  - What are the billing codes?……6
  - What modifiers are accepted?……6
  - How do I bill for implants?……8
  - How do I bill for injections?……9
- What payments can ASCs expect for services provided?……10
- When will the rates and policies for ASCs be updated?……11
- What are the documentation and record keeping requirements?……11
- Where is more information available?……11

Background

Currently L&I pays for services in ambulatory surgery centers (ASCs) at 100% of the allowed amount billed. This is in contrast to the way most other medical services are purchased, using payment methods such as fee schedules, discounting, and prospective payment. These methods help to assure that L&I meets its responsibility to purchase health care cost-effectively while assuring access to services.

The difference between an ASC, a physician surgical suite, and other outpatient surgical sites has not been reflected in payment policies for ASC type services. The scope of services that are appropriate in these types of facilities also has not been clearly defined. L&I currently pays ASCs and all other non-hospital surgical facilities or sites in the same manner.

What is Changing?

The department will now require minimum quality standards for ASCs to receive payment. The department will no longer pay for surgical facility services in an outpatient setting unless that facility has a provider account as an ASC or as an hospital.

For policies and guidelines regarding hospital and professional (i.e. physician and clinic) payments please refer to the Medical Aid Rules and Fee Schedules.

The department will be implementing a fee schedule for ASCs, which will be applied to payments for dates of service beginning on January 1, 2002. There are also changes with regard to coverage of procedures and payment policies. These are detailed in the following sections.

Why are these changes being made?

- To define the minimum standards required for an ASC to provide surgical services to Washington injured workers and crime victims.
- To revise the payment methodology for ASCs and other non-hospital surgical suites that provide surgical services to Washington injured workers and crime victims. Adoption of a prospective payment method will enable L&I to better manage its ASC and similar expenditures. It will also encourage cost effective use of ASC services.
- To make L&I's payment for ASC services more consistent with its payment methods for other providers and with other state and federal agencies.
- To standardize the payment rates for ASCs.
- To clarify what procedures are covered in an ASC.

Who may bill for Ambulatory Surgery Center services?

Only facilities that meet the criteria below may bill for ASC services.

An Ambulatory Surgery Center is an outpatient facility where surgical services are provided and that meets the following three requirements:

1. Must be licensed by the state(s) in which it operates, unless that state does not require licensure.
2. Must have at least one of the following credentials:
   a. Medicare Certification as an ambulatory surgery center; or

b. Accreditation as an ambulatory surgery center by a nationally recognized agency acknowledged by the Centers for Medicare and Medicaid Services (CMS).

3. Must have an active ambulatory surgery center provider account with the department of Labor and Industries.

What do I need to do if I already have a provider account with the department as an ASC?

Nothing. You already meet the requirements in the new rule.

If you have received updated licenses, certifications, or accreditations since your original application was submitted to Labor & Industries you may send in current copies of these documents to update your files with the department. You do not need to complete another application. Send them to the attention of Provider Accounts at Department of Labor and Industries, P.O. Box 44261, Olympia, WA 98504-4261.

What do I need to do if I have a provider account with the department as a physician, clinic, or other provider type and have been billing for ASC type services?

You need to submit another application to the department to obtain a separate provider account number as an ASC. You will not lose your current provider account number(s).

To receive facility payments for outpatient surgical services you must have an L&I provider account specifying "Ambulatory Surgery Center" as the provider type. Facilities with a provider account as a different provider type — such as physician or clinic — must meet the requirements listed above in order to qualify for an additional provider account as an ASC. See below to learn how to obtain an application.

How may an ASC obtain a provider account with the Department of Labor & Industries?

A provider account application may be obtained from Department of Labor & Industries, Provider Accounts, P.O. Box 44261, Olympia, WA 98504-4261, or by calling 360-902-5140. A copy can also be obtained online at www.lni.wa.gov (click on Forms, click on Provider, click on form number F248-011-000).

For the general explanation of the provider application process please see WAC 296-20-12401 in the *Medical Aid Rules and Fee Schedules* or online at www.lni.wa.gov (click on Medical Provider Information).

When filling out your application for a new provider number please put a check mark next to Ambulatory Surgery Center and include copies of your state license if the state you operate in requires one and copies of either your Medicare certification letter or your accreditation certificate. Please remember to fill out the application with the facility/business information. We do not need a list of individual professionals who work there or their licensing information.

How may a facility become accredited or Medicare certified as an Ambulatory Surgery Center?

Providers may contact the following organizations for more information:

National Accreditation
American Association for Accreditation of Ambulatory Surgery Facilities
1202 Allanson Road
Mundelein, IL 60060-3808
1-888-545-5222
www.aaaasf.org

Accreditation Association for Ambulatory Health Care
3201 Old Glenview Rd.
Wilmette, IL 60091
847-853-6060
www.aaahc.org

Joint Commission on Accreditation of Healthcare Organizations
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
630-792-5852
www.jcaho.org

Medicare Certification
Department of Health
Office of Health Care Survey
Facilities and Services Licensing
PO Box 47852
Olympia, WA 98504-7852
360-705-6612
email: fslhhhacs@doh.wa.gov
www.doh.wa.gov/hsqa/fsl/HHHACS_home.htm

Please note that it may take 3-6 months to get certification or accreditation.

What services are included in the ASC facility payment?

The following services are included in the facility payment for ASCs, and are not paid separately:

- Nursing, technician and related services.
- Use by the recipient of the facility, including the operating room and the recovery room.
- Drugs, biologics, surgical dressings, supplies, splints, casts and appliances and equipment directly related to the provision of surgical procedures.
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure.
- Administration, record keeping, and housekeeping items and services.
- Intraocular lenses.
- Materials for anesthesia.
- Blood, blood plasma and platelets.

What services are not included in the ASC facility payment?

The following services are **not** included in the facility payment for ASCs, and are paid separately:

- ❖ Professional services including physicians.
- ❖ Laboratory services.
- ❖ X-Ray or diagnostic procedures (other than those directly related to the performance of the surgical procedure).
- ❖ Prosthetics and Implants (except intraocular lenses).
- ❖ Ambulance services.
- ❖ Leg, arm, back and neck braces.
- ❖ Artificial limbs.
- ❖ Durable Medical Equipment (DME) for use in the patient's home.

What procedures are covered in an ASC?

The department will use the Centers for Medicare and Medicaid Services (CMS) list of procedures covered in an ambulatory surgery center plus additional procedures as determined by the department. All procedures covered in an ambulatory surgery center are listed in the *Medical Aid Rules and Fee Schedules, Ambulatory Surgery Center Payment Policies* section.

The department has decided to expand the list that CMS established for allowed procedures in an ASC. There are three areas where the list has been expanded:

1) Labor & Industries will cover surgical procedures that other Washington State agencies cover in ASCs and that meet L&I's coverage policies.
2) Labor & Industries will cover surgical procedures that CMS covers in its hospital outpatient prospective payment system called Ambulatory Payment Classifications (APCs) that are not on the CMS ASC list.
3) Labor & Industries will cover some procedures in an ASC that CMS covers only in an inpatient setting, if the following criteria are met:
   a) The surgeon deems that it is safe and appropriate to perform such a procedure in an outpatient setting; and
   b) The procedure meets the department's utilization review requirements.

Copies of the *Medical Aid Rules and Fee Schedules* may be obtained from Department of Labor and Industries, Warehouse, P.O. Box 44843, Olympia, WA 98504-4843 or 360-902-5754. **(The hard copy version of the *Ambulatory Surgery Center Payment Policies* section is available by calling Provider Hotline at 1-800-848-0811 until July 2002, after which it will be published in the *Medical Aid Rules and Fee Schedules,* annually.)** The *Medical Aid Rules and Fee Schedules* including the *Ambulatory Surgery Center Payment Policies* section is available online at www.lni.wa.gov (click on Medical Provider Information, then click on Medical Provider Fee Schedule, then click on the highlighted Medical Aid Rules and Fee Schedules and accept the license for use, then click on Errata and Replacement Pages, look for ASC section).

What procedures are not covered in an ASC?

Procedures that are not listed in the *Ambulatory Surgery Center Payment Policies* section of the *Medical Aid Rules and Fee Schedules* are not covered in an ASC.

ASCs will not receive payment for facility services for minor procedures, which are commonly done in an office setting or treatment room. See below for exceptions to this condition. The professional performing such procedures may still bill for and will receive payment for the professional component of such procedures.

What do I do if I believe that a procedure not on the approved ASC coverage list needs to be performed in an ASC?

Under certain conditions, the director, the director's designee, or self-insurer, in their sole discretion, may determine that a procedure not on the list may be authorized in an ambulatory surgery center. For example, if the procedure could be harmful to a particular patient unless performed in an ambulatory surgery center. Requests for coverage under these special circumstances require prior authorization. The process for requesting authorization is outlined in the *Medical Aid Rules and Fee Schedules, Ambulatory Surgery Center Payment Policies* section and below.

The health care provider must submit a written request and obtain approval from the department or self-insurer, prior to performing any procedure not on the ASC procedure list. The written request must contain a description of the proposed procedure with associated procedure codes, the reason for the request, the potential risks and expected benefits, and the estimated cost of the procedure. The healthcare provider must provide any additional information about the procedure that may be requested by the department or self-insurer.

What are the authorization requirements?

All current department of Labor & Industries utilization review and authorization requirements remain in effect. Any procedure not on the ASC approved procedure list will require pre-authorization as described above.

For information on the current utilization review and authorization requirements see the following WACs and Provider Bulletins:

- WAC 296-20-024 for utilization management authority.
- WAC 296-20-01002 for definition of utilization review.
- WAC 296-20-02700 through 296-20-03002 for medical coverage policies.
- Provider Bulletin, PB 00-08, describing the utilization review program.

These may be viewed online at www.lni.wa.gov (click on Medical Provider Information).

What are the billing rules?

Billing procedures are outlined in WAC 296-20-125 and in the *General Provider Billing Manual* and *Billing Instructions* available online at www.lni.wa.gov (click on Medical Provider Information, then click on Provider Payment Information).

What form should be used?
ASCs must currently bill services on a HCFA 1500 form or by using the electronic file format specified by the department. Information on how to bill electronically can be found on the web site mentioned above. Charges submitted on any other form, such as a UB92, will cause the bill to be denied.

What are the billing codes?
Use the appropriate Physicians' Current Procedural Terminology (CPT®) or HCFA Common Procedure Coding System (HCPCS) procedure codes.*

What modifiers are accepted?
The SG modifier may accompany all CPT® and HCPCS codes. The department will no longer accept the 1M modifier, as of January 1, 2002.

---

* CPT is registered trademark of the American medical Association.

The department will accept modifiers listed in the CPT® and HCPCS books including those listed as approved for ASCs. A full list of modifiers acceptable for ASC use, are listed in the *Medical Aid Rules and Fee Schedule, Ambulatory Surgery Center Payment* section. Only modifiers affecting payment are listed below:

-50 Bilateral surgery
Modifier -50 identifies cases where a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using two line items on the bill form. The modifier -50 should be applied to the second line item. The second line item will be paid at 50% of the allowed amount for that procedure. See "How do I bill for injections?" for instructions specific to those types of bilateral procedures.

Example: **Bilateral Procedure**

Line item on bill	CPT® code/modifier	Maximum payment (Group 2)	Bilateral policy applied	Allowed amount
1	64721- SG	$1,130.28		$1,130.28 (1)
2	64721 – SG - 50	$1,130.28	$565.14 (2)	$565.14
Total allowed amount				**$1695.42** (3)

Notes:
1. First line item is paid at 100% of maximum allowed amount.
2. When applying the bilateral payment policy the second line item billed with a modifier –50 is paid at 50% of the maximum allowed amount for that line item.
3. Represents total allowable amount.

-51 Multiple surgery
Modifier -51 identifies when multiple surgeries are performed on the same patient at the same operative session. Providers must bill using two line items on the bill form. The modifier -51 should be applied to the second line item. The total payment equals the sum of:

100% of the maximum allowable fee for the highest valued procedure according to the fee schedule.

50% of the maximum allowable fee for the subsequent procedures with the next highest values, according to the fee schedule.

Example: **Multiple Procedures**

Line item on bill	CPT® code/modifier	Maximum payment (Groups 9 & 2)	Multiple policy applied	Allowed amount
1	29881 – SG	$2,107.75		$2,107.75 (1)
2	64721 – SG - 51	$1,130.28	$565.14 (2)	$565.14
Total allowed amount				**$2672.89** (3)

Notes:
1. Highest valued procedure is paid at 100% of maximum allowed amount.
2. When applying the multiple procedure payment policy the second line item billed with a modifier -51 is paid at 50% of the maximum allowed amount for that line item.
3. Represents total allowable amount.

-73 Discontinued procedure prior to the administration of anesthesia
Modifier –73 is used when a physician cancels a surgical procedure due to the onset of medical complications subsequent to the patient's preparation, but prior to the administration of anesthesia. Payment will be at **50%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

-74 Discontinued procedure after administration of anesthesia
Modifier –74 is used when a physician terminates a surgical procedure due to the onset of medical complications after the administration of anesthesia or after the procedure was started. Payment will be at **100%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

-99 Multiple modifiers
This modifier should only be used when two or more modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the actual services performed. For billing purposes, only modifier -99 should go in the modifier column, with the individual descriptive modifiers that affect payment listed in the remarks section of the billing form.

How do I bill for implants?
Implants should be billed on a separate line. The following HCPCS implant codes are covered by the department in an ASC: L8500 through L8699. ASCs will be paid acquisition cost for implants.

Exception:
L8603 has a maximum fee and pays the lesser of the maximum fee or acquisition cost.

Exception:
Intraocular lenses, including new technology lenses, are bundled into the fee for the associated procedure. Please include the cost of the lens in the charge for the procedure. It is permissible to include a line on the bill with the HCPCS code for an intraocular lens (i.e. V2630, V2631, V2632, Q1001, Q1002) and its associated cost, for information purposes only.

Acquisition Cost:
The acquisition cost equals the wholesale cost plus shipping, handling, and sales tax. These items should be billed together as one charge.

Wholesale invoices for all supplies and materials must be retained in the provider's office files for a minimum of five years. A provider must submit a hard copy of the wholesale invoice to the department or self-insurer when an individual supply costs $150.00 or more, or upon request. The insurer may delay payment of the provider's bill if the insurer has not received this information.

Example: **Procedure with Implant**

Line item on bill	CPT® code/modifier	Maximum payment (Group 9)	Allowed amount
1	29851- SG	$2,107.75	$2,107.75 (1)
2	L8699	$150.00 (acquisition cost)	$150.00 (2)
Total allowed amount			**$2,257.75** (3)

Notes:
1. Procedure is paid at 100% of maximum allowed amount.
2. Represents the total of wholesale implant cost plus associated shipping, handling, and taxes.
3. Represents total allowable amount.

Tip:
Do not use the new temporary "C" HCPCS codes, as that will cause the bill to be denied.

How do I bill for injections?
Injection procedures are billed in the same fashion as all other surgical procedures with the following considerations:

For purposes of multiple procedure discounting, each procedure in a bilateral set is considered to be a single procedure.

Some injection procedures require the use of radiographic localization and guidance. This is commonly accomplished with a fluoroscope or C-arm. ASCs must use fluoroscopy with the following injections codes: 62263 – 62319 and 64470 – 64484. ASCs must include the code 76005 – TC with the bill for the injection, to be paid for the technical component of operating the fluoroscope or C-arm. A maximum fee has been set for the code 76005 – TC, fluoroscopic guidance and localization for spinal injection.

Example: **Injection Procedures**

Line item on bill	CPT® code/modifier	Maximum payment (Groups 1)	Bilateral/Multiple policies applied	Allowed amount
1	64470 – SG	$843.10		$843.10 (1)
2	64470 – SG - 50	$843.10	$421.55 (2)	$421.55
3	64472 – SG	$843.10	$421.55 (3)	$421.55
4	64472 – SG - 50	$843.10	$421.55 (2)	$421.55
5	76005 –TC	$67.46		$67.46 (4)
Total allowed amount				**$2,175.21** (5)

Notes:
1. Highest valued procedure is paid at 100% of maximum allowed amount.
2. When applying the bilateral procedure payment policy the second line item billed with a modifier -50 is paid at 50% of the maximum allowed amount for that line item.
3. The multiple procedure payment policy is applied to subsequent procedures billed on the same day and are paid at 50% of the maximum allowed amount for that line item.
4. This is the fee schedule maximum allowed amount for the fluoroscopic localization and guidance.
5. Represents total allowable amount.

What payments can ASCs expect for services provided?

The department pays the lesser of the billed charge (the ASC's usual and customary fee) or the fee schedule's maximum allowed rate. The fee schedule for ambulatory surgery centers is in the *Medical Aid Rules and Fee Schedules*. A supplement will be available online at www.lni.wa.gov/hsa/ascpmp.htm. A hard copy is available by calling Provider Hotline at 1-800-848-0811 until July 2002, after which it will be published in the *Medical Aid Rules and Fee Schedules*, annually.

Payments are based on a grouping system developed by Medicare for ASC services. The department has modified Medicare's grouping system to fit a worker's compensation population. Surgical services have been divided into 9 payment groups each with an associated maximum allowable fee.

Group	Fee
1	$843.10
2	$1,130.28
3	$1,293.63
4	$1,596.63
5	$1,817.95
6	$2,107.75
7	$2,521.40
8	$2,481.80
9	$2,107.75

Three codes have maximum fees set that are not part of these groups.

Code	Description	Fee
63030	Laminotomy, one interspace, lumbar	$4800.00
76005	Fluoroscopic localization & guidance for injection	$67.46
L8603	Collagen implant, urinary 2.5 ml	$354.95

Procedures allowed by L&I and not grouped by Medicare or another Washington State agency will be paid "By Report." In the future the department may assign maximum fees to some of these procedures or assign them to groups.

When will the rates and policies for ambulatory surgery centers be updated?

The fee schedule, codes, and policies for ambulatory surgery centers will be reviewed periodically. The department will publish provider bulletins to clarify, update, and inform ambulatory surgery centers about changes in policies or fees. They also will be published each July in the *Medical Aid Rules and Fee Schedules*.

Annually, the department will evaluate the need for a cost of living adjustment and may apply it to the ASC fee schedule. ASCs will be advised of this by the methods stated above.

What are the documentation and record keeping requirements?

WAC 296-20-02005 describes the department's record keeping requirements for all healthcare providers. There are no additional requirements for ASC services.

Where is more information available?

For background information on the Ambulatory Surgery Center Payment Project and a copy of the new rule affecting Ambulatory Surgery Centers you may go to the following web site:
http://www.lni.wa.gov/hsa/ascpmp.htm

Complete text of the laws and rules pertaining to workers compensation can be found at http://slc.leg.wa.gov/ or by calling 1-800-537-7881 and requesting an order form from Office of the Code Reviser. Or, you may call 1-800-848-0811 and request copies from the department of Labor & Industries.

Service providers involved in the care and treatment of injured workers can call the Provider Hotline at 1-800-848-0811 to obtain or initiate authorization for services and for answers to billing questions.